



"People
helping people
help
themselves"

Division of Mental Health and Addiction
402 W. WASHINGTON STREET, ROOM W353
INDIANAPOLIS, IN 46204-2739
317-232-7800
FAX: 317-233-3472

Community-Based Options for Youth and Families
Intensive Home and Community-Based Wraparound Services
Consultative and Clinical Therapy Service
Provider Certification Form

Date of Application:

Service Program (Check all that apply):
<input type="checkbox"/> PRTF Transition Waiver <input type="checkbox"/> MFP-PRTF Demonstration Grant

Type of Provider (Check one):
<input type="checkbox"/> Accredited Agency <input type="checkbox"/> Non-Accredited Agency <input type="checkbox"/> Individual

Provider Information:

Name of Agency (if applicable):
Name of Applicant:

Phone number of person completing form:
Email of person completing form:

Agency Requirements (Check any that apply):

<i>Proof of Agency Status</i>
<input type="checkbox"/> Certification by the Division of Mental Health and Addiction (DMHA) as a Community Mental Health Center <input type="checkbox"/> Approved accreditation by a nationally recognized accrediting body: AAAHC, COA, URAC, CARF, ACAC, JCAHO, OR NCQA <input type="checkbox"/> Articles of Incorporation

Provider Criteria and Standards: Checking the items below is an acknowledgement that the staff member meets the required criteria and standards for this service:

<i>Clinical Requirements</i>
<input type="checkbox"/> Qualifies as one of the following licensed behavioral health providers: a) HSPP as defined in IC-25-33-1; b) Licensed Marriage and Family Therapist under IC 25-23.6; c) Licensed Clinical Social Worker under IC 25-23.6; or d) Licensed Mental Health Counselor under IC 25-23.6.
<i>Other Standards</i>
<input type="checkbox"/> Finger-print based national and state criminal history background screen <input type="checkbox"/> Local law enforcement screen <input type="checkbox"/> State and local Department of Child Services abuse registry screen <input type="checkbox"/> Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1)
<i>Training</i>
<input type="checkbox"/> Provider Orientation Training <input type="checkbox"/> Introduction to Systems of Care and Wraparound 101 Training <input type="checkbox"/> CPR Certification

Note: DMHA will only process complete packets. All incomplete packets will be recycled. DMHA is responsible for verifying an agency meets the above qualifications initially and at renewal of license or accreditation.

Documentation Requirements:

<i>Submit copies of the documentation below, as indicated by the type of provider applying for certification</i>	Accredited Agency*	Non-Accredited Agency or Individual Provider
Provider Type Documentation:		
<input type="checkbox"/> CMHC Certification (If an Accredited Agency, submit a copy)	X	
<input type="checkbox"/> Proof of National Accreditation (If an Accredited Agency, submit a copy)	X	
<input type="checkbox"/> Articles of Incorporation (If a Non-Accredited Agency, submit a copy)		X
Clinical Documentation:		
<input type="checkbox"/> Provider licensure (Copy)	X	X
Other Standards Documentation:		
<input type="checkbox"/> Finger-print based national and state criminal history background screen results	X	X
<input type="checkbox"/> Local law enforcement screen results	X	X
<input type="checkbox"/> State and local Department of Child Services abuse registry screen results	X	X
<input type="checkbox"/> Five-panel drug screen results (<i>Not applicable if Agency meets same requirements specified under the Federal Drug Free Workplace Act</i>)	X	X
Training Documentation:		
<input type="checkbox"/> Provider Orientation Training (Copy of certificate)	X	X
<input type="checkbox"/> Introduction to Systems of Care and Wraparound 101 Training (Copy of certificate)	X	X
<input type="checkbox"/> CPR Certification (Copy of certificate)	X	X
Miscellaneous Documentation:		
<input type="checkbox"/> Provider Demographic Form (Signed original)	X	X
<input type="checkbox"/> Provider Agreement (Signed original)	X	X
<input type="checkbox"/> Picture ID/Driver's License (Picture of person on card must be recognizable)	X	X

***Accredited Agency Note:** *The provider agency must maintain documentation that Applicant meets the required criteria and standards for the Consultative and Clinical Therapy service; and have records available for DMHA to complete quality review audits. Failure to provide documentation for DMHA inspection may result in corrective action up to and including decertification of agency.*

Return completed forms and required documentation to DMHA:

Division of Mental Health and Addiction
 Attn: Community-Based Options for Youth & Families Team
 402 W. Washington St., W353
 Indianapolis, IN 46204-2739

Policy/Procedure Approval		
Revised: Apr 2013	Consultative and Clinical Therapy Service Certification Form	
OMPP Approval:	On file	Date: April 2013
DMHA Approval:	On file	Date: April 2013